


Plan of Correction

Program Name: Pennington County Sheriff's Office-Addiction Treatment Services	Date Submitted: 11/21/2019	Date Due: 12/21/2019
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Administrative POC-1	
Rule #: ARSD 67:61:04:01	Rule Statement: Policies and procedures manual. Each agency shall have a policy and procedure manual to establish compliance with this article and procedures for reviewing and updating the manual.
Area of Noncompliance: There were policy and procedures still referencing the old rules of 46:05.	
Corrective Action (policy/procedure, training, environmental changes, etc): Beginning 11/22/19 the Directors will meet weekly for 2 hours to update all policies and procedures to ensure compliance with requirements of ARSD 67:61:04:01	Anticipated Date Achieved/Implemented: Date May 1, 2020
Supporting Evidence: 	Person Responsible: Directors
How Maintained: Once all policies and procedures have been brought into compliance, will make changes as changes occur in ARSD. Will also review annually.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-2	
Rule #: Contract Attachment 1	Contract Attachment: <u>Populations to be Served</u> It is the intent of the Division of Behavioral Health to fund services in South Dakota for residents living in South Dakota. It is the Division's expectation that state funds be targeted to those citizens of South Dakota in need of substance use disorder and gambling treatment services. Priority Populations: Target populations to be served under the contract, in order of priority for State and Federal funds paid to the agency, and in accordance with 45 CFR 96.124 and 45 CFR 96.131, are as follows: 1) Pregnant Women <ol style="list-style-type: none"> Agencies must ensure that each pregnant woman in the state who seeks or is referred for and would benefit from treatment is given preference in admissions to treatment facilities receiving block grant funds. The agency shall publicize by public service announcement or street outreach programs the availability to such women of these treatment services designed for pregnant women and women with dependent children. Services for pregnant women/women with dependent children must comply with the provisions set forth in 45 CFR Sec. 96.124.

	<p>d) Pregnant Women who are also Intravenous Drug Users are the highest priority for services.</p> <p>2) Intravenous Drug Users</p> <p>a) The agency shall develop and implement a program of outreach services to identify individuals in need of treatment for their intravenous drug use and to encourage the individual to undergo treatment for such use.</p> <p>b) The agency shall maintain a record of outreach services provided to intravenous drug users.</p> <p>c) Services for intravenous drug users must comply with the provisions set forth in 45 CFR 96.124 and 45 CFR 96.131.</p> <p>d) The agency shall develop and implement a policy to ensure that they will not distribute sterile needles or distribute bleach for the purpose of cleaning needles and shall develop and implement a policy to ensure they will not carry out any testing for the acquired immune deficiency syndrome without appropriate pre- and post-test counseling.</p> <p>3) Adolescents</p> <p>Limited English Proficiency Policy</p> <p>1) The agency shall develop and implement a Limited English Proficiency Policy (LEP), as a condition for funding under this contract agreement to ensure that LEP individuals are provided with an opportunity to participate in and understand all provided services.</p> <p>2) The means of effective communication may be through interpreters or the translation of written material as deemed necessary by the Agency.</p>
<p>Area of Noncompliance: A policy regarding the contract attachment was not found in review of policy and procedures manual.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): A policy will be created to ensure the target populations will be served by the priorities as outlined in 45 CFR 96.124 and 45 CFR 96.131. A separate policy will be developed for the LEP to ensure that all individuals are provided an opportunity to participate in and understand the provided services</p> <p>Supporting Evidence: [REDACTED]</p>	<p>Anticipated Date Achieved/Implemented:</p> <p>Date March 1, 2020</p> <p>Person Responsible: Directors</p>
<p>How Maintained: Will review for any updated provisions annually</p>	<p>Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Administrative POC-3	
Rule #: ARSD 67:61:06:02	Rule Statement: Guaranteed rights. A client has rights guaranteed under the constitution and laws of the United States and the state of South Dakota including: <ol style="list-style-type: none"> 1) The right to refuse extraordinary treatment as provided in SDCL 27A-12-3.22; 2) The right to be free of any exploitation or abuse; 3) The right to seek and have access to legal counsel; 4) To have access to an advocate as defined in subdivision 67:61:01:01(4) or an employee of the state's designated protection and advocacy system;

	<p>5) The right to confidentiality of all records, correspondence, and information relating to assessment, diagnosis, and treatment in accordance with the confidentiality of records requirements of the Substance Abuse and Mental Health Services Administration, 42 U.S.C. §§ 290 dd-2 (January 7, 2011), the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2 (June 9, 1987), and the security and privacy of HIPAA, 45 C.F.R. Part 160 and 164 (September 26, 2016); and</p> <p>6) The right to participate in decision making related to treatment, to the greatest extent possible.</p>
Area of Noncompliance: Two or the six guaranteed client rights were missing from the policy.	
Corrective Action (policy/procedure, training, environmental changes, etc): Will update policy CC210-007 to reflect ARSD 67:61:06:02. Will also update the Client Handbook and Clients Guaranteed Rights form and post throughout the agency	Anticipated Date Achieved/Implemented: Date 12/31/2019
Supporting Evidence:	Person Responsible: Director
How Maintained: Will review Administrative Rules annually and update policy/procedure above to reflect changes to ARSD 67:61:06:02	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-4	
Rule #: ARSD 67:61:05:01	Rule Statement: Tuberculin screening requirements. Tuberculin screening requirements for employees are as follows: <ol style="list-style-type: none"> 1) Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test; 2) A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; 3) Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of <i>Myobacterium tuberculosis</i>. If this evaluation results in suspicion of active tuberculosis, the

	<p>licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and</p> <p>4) Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.</p>
Area of Noncompliance: A personal file was missing a TB within 14 days of hire.	
Corrective Action (policy/procedure, training, environmental changes, etc): Per global policy GP8-50 all employees are to have a TB screen completed within the first 14 days. To ensure that all TB tests are completed within this timeframe, the Directors will verify the testing has been completed when doing orientation with the new employee. If it has not a test will be conducted at that time. A copy of this test will be saved in both personnel files as well as maintaining a hard file in a binder on site.	Anticipated Date Achieved/Implemented: Date 01/01/2020
Supporting Evidence:	Person Responsible: Deanna Nolan/David Oster
How Maintained: For each new hire, will include a copy of the TB test with the orientation paperwork and will send to HR for the personnel file and give original to Nursing staff to maintain on site.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-5	
Rule #: ARSD 67:61:07:04	Rule Statement: 67:61:07:04. Closure and storage of case records. The agency shall have written policies and procedures to ensure the closure and storage of case records at the completion or termination of a treatment program including: <ul style="list-style-type: none"> 1) The identification of staff positions or titles responsible for the closure of case records within the agency and the MIS; 2) Procedures for the closure of inactive client records, that are clients who have not received services from an inpatient or residential program in three days or clients who have not received services from an outpatient program in 30 days; and 3) Procedures for the safe storage of client case records for at least six years from closure.
Area of Noncompliance: Inactive clients and timeframes of case closure for residential and outpatient are needed.	
Corrective Action (policy/procedure, training, environmental changes, etc): To comply with ARSD 67:61:07:04 the policy/procedure CC230-001 on Case records will be updated to include the above	Anticipated Date Achieved/Implemented: Date 1/15/2020
Supporting Evidence:	Person Responsible: Deanna Nolan

How Maintained: Administrative Rules will be reviewed annually. Any further changes to ARSD 67:61:07:04 will be made to the policy/procedure noted above.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>
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Client Chart POC-1	
Rule #: ARSD 67:61:07:08	Rule Statement: Progress notes. All programs, except prevention programs, shall record and maintain a minimum of one progress note weekly. Progress notes are included in the client's file and substantiate all services provided. Individual progress notes shall document counseling sessions with the client, summarize significant events occurring, and reflect goals and problems relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes shall include attention to any co-occurring disorder as they relate to the client's substance use disorder. A progress note is included in the file for each billable service provided. Progress notes shall include the following for the services to be billed: <ol style="list-style-type: none"> 1) Information identifying the client receiving services, including name and unique identification number; 2) The date, location, time met, units of service of the counseling session, and the duration of the session; 3) The service activity code or title describing the service code or both; 4) A brief assessment of the client's functioning; 5) A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives; 6) A brief description of what the client and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and 7) The signature and credentials of the staff providing the service.
Area of Noncompliance: Many of the charts were missing an individualized brief description of what the client and provider plan to work on during the next sessions, including work that may occur between sessions, if applicable.	
Corrective Action (policy/procedure, training, environmental changes, etc): Counselors will be provided additional training on the correctly completing progress notes. Specifically on the individualized plan for the next session.	Anticipated Date Achieved/Implemented: Date 01/01/2019 Person Responsible: Amanda Whelchel/Kate Dietz
Supporting Evidence:	
How Maintained: Clinical Supervisors will spot check files monthly to ensure the progress notes are in compliance.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

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Client Chart POC-2	
Rule #: ARSD 67:61:07:07	Rule Statement: Continued service criteria. The program shall document for each client the progress and reasons for retaining the client at the present level of care; and an individualized plan of action to address the reasons for retaining the individual in the present level of care. This document is maintained in the client case record. It is appropriate to retain the client at the present level of care if: <ol style="list-style-type: none"> 1) The client is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 2) The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 3) New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the client is receiving treatment is therefore, the least intensive level at which the client's new problems can be addressed effectively. <p>The individualized plan of action to address the reasons for retaining the individual in the present level of care shall be documented every:</p> <ol style="list-style-type: none"> 1. 14 calendar days for: <ol style="list-style-type: none"> a. Early intervention services; b. Intensive outpatient services; 2. 30 calendar days for: <ol style="list-style-type: none"> a. Outpatient treatment program; and
Area of Noncompliance: Continued stay reviews had the same individual plan of action that addressed why the individual was in the present level of care.	
Corrective Action (policy/procedure, training, environmental changes, etc): Counselors will be provided additional training on completing and individualized plan of action for the CSR's	Anticipated Date Achieved/Implemented: Date 01/01/2019
Supporting Evidence:	Person Responsible: Amanda Whelchel/Kate Dietz
How Maintained: Clinical Supervisors will spot check files monthly to ensure CSR's are in compliance.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

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Client Chart POC-3	
Rule #: ARSD 67:61:07:10	Rule Statement: Transfer or discharge summary. An addiction counselor or counselor trainee shall complete a transfer or discharge summary for any client within five working days after the client is discharged regardless of the reason for discharge. A transfer or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan is maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. When a client prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the client into services if appropriate.
Area of Noncompliance: The transfer or discharge summaries were missing one or more of the required elements.	
Corrective Action (policy/procedure, training, environmental changes, etc): Counselors will be provided training on completing the required elements for transfer or discharge summaries	Anticipated Date Achieved/Implemented: Date 01/01/2019
Supporting Evidence:	Person Responsible: Amanda Whelchel/Kate Dietz
How Maintained: Clinical Supervisors will spot check files monthly to ensure the transfer or discharge summaries are in compliance	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-4	
Rule #: ARSD 67:61:07:12	Rule Statement: Tuberculin screening requirements. A designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment, intensive outpatient, day treatment, clinically-managed low intensity residential treatment, clinically managed detoxification, and intensive inpatient treatment within 24 hours of admission to determine if the client has had any of the following symptoms within the previous three months: (1) Productive cough for a two to three week duration; (2) Unexplained night sweats; (3) Unexplained fevers; or (4) Unexplained weight loss. Any client determined to have one or more of the above symptoms within the last three months shall be immediately referred to a licensed physician for a medical evaluation to determine the absence or presence of active disease. A Mantoux skin test may or may not be done during this evaluation based on the opinion of the evaluating physician. Any client confirmed or suspected to have infectious tuberculosis shall be excluded from services until the client is determined to no longer be infectious by the physician. Any client in which

infectious tuberculosis is ruled out shall provide a written statement from the evaluating physician before being allowed entry for services.	
Area of Noncompliance: TB screen was not completed within 24 hours of admission for several charts.	
Corrective Action (policy/procedure, training, environmental changes, etc): The TB screening for outpatient services (IOP and CJI) will be conducted on the day of admission versus the day of the intake.	Anticipated Date Achieved/Implemented: Date 12/10/2019
Supporting Evidence:	Person Responsible: All counselors
How Maintained: Clinical Supervisors will spot check files monthly to ensure compliance.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-5	
Rule #: ARSD 67:61:17:02	Rule Statement: Information required to be obtained at time of admission. The agency admitting the client shall obtain the information required by § 67:61:17:07(1), and record the following observations and information in the client's case record: <ol style="list-style-type: none"> 1) Blood pressure, pulse, and respiration; 2) Presence of bruises, lacerations, cuts, or wounds; 3) Medications the client is currently taking, particularly sedative use; 4) Medications carried by the client or found on the client's person; 5) Any history of diabetes, seizure disorders including epilepsy, delirium tremens, and any client history of convulsive therapies, e.g., electroconvulsive or insulin shock treatments, and any history of exposure to tuberculosis and any current signs or symptoms of the disease; 6) Any history of medical, psychological, or psychiatric treatment; and 7) Any symptoms of mental illness currently present.
Area of Noncompliance: Complete vitals were missing at time of admission on two charts reviewed.	
Corrective Action (policy/procedure, training, environmental changes, etc): Tech staff will collect vitals on all clients being admitted into detox services per administrative rule and policy CC560-002. If a client is taken straight to an Isolation unit due to aggression, at the very minimum the respiration and any presence of bruises, lacerations, cuts or wounds will be noted on the vitals card. A full set of vitals will be collected as staff can safely collect them.	Anticipated Date Achieved/Implemented: Date 12/16/2019

Supporting Evidence: [REDACTED]	Person Responsible: David Oster
How Maintained: A periodic chart review will be completed by tech supervisors to ensure compliance	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-6	
Rule #: ARSD 67:61:17:05	Rule Statement: Monitoring and documentation of client's condition. The program shall establish a written policy and procedure concerning the steps staff shall take when assessing and monitoring a client's physical condition and responding to medical complications throughout the detoxification process. Staff shall closely monitor the condition of each client during detoxification and document the following information in the client's case record: 1) Blood pressure, pulse, and respiration; at admission by staff trained to perform these tests, a minimum of two additional times in the first eight hours after admission, or at a greater frequency dependent on the degree of hypertension or hypotension, and at least once every eight hours thereafter; 2) Physical, mental, and emotional state, including presence of confusion, anxiety, depression, hallucinations, restlessness, sleep disturbances, tremors, ataxia, or excessive perspiration; and 3) Type and amount of fluid intake.
Area of Noncompliance: Two sets of vitals were missing within 8 hours of admission and every 8 hours thereafter.	
Corrective Action (policy/procedure, training, environmental changes, etc): Tech staff will collect vitals on all clients as noted in the administrative rule and per policy CC560-003. If client is sleeping, vitals will still be collected. If refused, this will be clearly documented on the vitals card (ie: clients words verbatim). The vitals card will be updated to reflect how many ounces per cup so fluid intake can more accurately be documented.	Anticipated Date Achieved/Implemented: Date 12/16/2019
Supporting Evidence: [REDACTED]	Person Responsible: David Oster
How Maintained: A periodic chart review will be completed by tech supervisors to ensure compliance	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-7	
Rule #: CJI Program Guidelines	Rule Statement: CJI program guidelines: <ul style="list-style-type: none"> The agency will document weekly progress reports to the client's probation officer or the referral source The agency will document a client's discharge summary was sent to the referral source

	<ul style="list-style-type: none"> The agency will document if the client has an extension form (if applicable) in the client's file
Area of Noncompliance: The agency did not have documentation that the weekly progress reports or discharge summaries sent to the referral source.	
Corrective Action (policy/procedure, training, environmental changes, etc): Weekly emails will be sent to each client's referral source indicating progress/regress. This correspondence will be added to the client file weekly. All Discharge Summaries will also be sent to the referral source via email. This correspondence will be added to the client file as the file is being closed	Anticipated Date Achieved/Implemented: Date 12/16/2016
Supporting Evidence:	Person Responsible: Amanda Whelchel/Kate Dietz
How Maintained: Clinical Supervisors will spot check files monthly to ensure compliance.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Program Director Signature: 	Date: 12/11/19
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Please email or send Plan of Correction to:

Accreditation Program
 Department of Social Services
 Division of Behavioral Health
 3900 West Technology Circle, Suite 1
 Sioux Falls, SD 57106
 Email Address: DSSBHAccred@state.sd.us